PostScript

ADOLESCENT SEXUAL HEALTH LETTERS

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HIV tests in young adolescents attending a GUM clinic

A pretest counselling session is recommended by the General Medical Council before carrying out an HIV test and it is generally accepted that adolescents deemed competent enough to understand the counselling process can have an HIV test without parental consent. A recent survey in the United Kingdom showed that 79% of clinics were prepared to test for HIV infection in children under the age of 16.[1] We reviewed the characteristics of adolescents between the ages of 13 and 16 seen in the Coventry genitourinary medicine (GUM) clinic for an HIV test between 1990 and 2000 (table 1). This was part of a larger review of GUM attendances by children, the results of which have been published.[2]

The commonest mode of presentation was a specific request for an HIV test. This was the case in 32 (39.0%) adolescents. Eighteen adolescents (22.0%) coming in requesting a check up were also offered an HIV test, 22 (26.8%) alleged rape/assault, 14 (17.1%) complained of a discharge, and four (4.9%) had a needlestick injury.

Ten (12.2%) of the adolescents seen had a sexually transmitted infection diagnosed (eight girls (11.4%) versus two boys (16.7%); p=0.6). Genital chlamydial infection was diagnosed in five cases, gonorrhoea in two cases, and there was one case each of genital herpes, *Trichomonas vaginalis*, and genital wart infection. Having a sexually transmitted infection diagnosed was associated with complaining of a discharge (12.5% versus 50.0% p=0.003) and prostitution (1.4% versus 20.0% p=0.03) but not with any other presenting complaint.

Table 1 Demographics

Total number	82
Female	70 (85.4%)
Accepting to have HIV test	70 (85.4%)
Median age	15
Virgins	8 (9.8%)
Prostitutes	3 (3.7%)
Injecting drug users	3 (3.7%)
Positive for HIV antibodies	0

Adolescents coming in specifically requesting an HIV test were more likely to accept it following counselling than those who did not (96.9% versus 78.0%, p=0.02). Acceptance of HIV test was, however, unrelated to the sex of child, prostitution, more than one partner in the previous year, or being diagnosed with a sexually transmitted infection. There was no statistically significant difference between those claiming rape/assault and those who were not in having an HIV test after counselling (95.5% versus 81.7%, p=0.1).

There is no specific literature regarding the factors associated with HIV testing in young adolescents. A study of sexually active 16–19 year olds in Massachusetts found that infrequent condom use and a history of sexually transmitted disease were not significantly associated with voluntary HIV testing.[3] Having had more than one sexual partner in the past year and discussing HIV/AIDS with a doctor were however associated with voluntary HIV testing. Previous discussion of HIV testing with a healthcare provider was also identified as a predictor of HIV testing in another study.[4] Misconceptions about HIV test results and condom use as well as not having discussed HIV with a teacher are also associated with voluntary HIV testing.[3]

It has been shown that most adolescents engaging in high or moderate HIV risk behaviour continued to do so into young adulthood. Knowledge about HIV infection and its prevention, estimates of personal risk or exposure to HIV test counselling were not associated with a change in behaviour.[5] Effort must therefore be directed at research into adolescent risk behaviour change.

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Sexual and reproductive health among female adolescents: preliminary results

The recognition of adolescence as an essential formative stage of life has implications for programming content and approaches.[1] Young people have to be treated as people in their own right, and their individual needs considered on a case to case basis. The realisation that this is a time of significant opportunities and risks highlights the urgency to deal directly with sensitive topics such as sex and drugs.[2]

The aim of this study was to identify demographic, behavioural and clinical factors for STI and unplanned pregnancy among female adolescents assisted by the family health programme (PSF) of Vitória Municipality in Brazil. A cross sectional study was performed among female adolescents (15–19 years old) assisted by the PSF. Participants were screened for *Chlamydia trachomatis* and *Neisseria gonorrhoeae* using ligase chain reaction (LCR) applied to urine and answered a face to face questionnaire. Standard descriptive statistical analysis was performed. Prevalence rates were calculated to reflect the relative frequency of each disease, with corresponding 95% confidence intervals (CI). The national school of public health (FIOCRUZ) ethics committee approved this study. Written, informed consent was obtained by all participants and their parents.

The study included 149 adolescents. Mean age was 17.2 (SD 1.5) years; mean education was 8.3 (SD 2.9) years of schooling, and the mean age of the first sexual intercourse was 15.4 (SD 1.6) years. Seventy per cent of adolescents have already had sexual intercourse. Among those the prevalence rate of CT was 11.4% (95% CI 7.6 to 14), 4.0% (95% CI 2.1 to 5.2) of GC. Behaviour and clinical data are reported in table 1. There was statistical significance between chlamydia infection and previous STI (OR = 20.1, 95% CI: 5.9 to 67.9); gonorrhoea and no condom use (OR = 1.2, 95% CI: 1.06 to 1.12); and gonorrhoea and alcohol abuse (OR = 1.3, 95% CI: 1.1 to 2.1). Clinical problems identified were genital ulcer 6.0%, dysuria 15.4%, inguinal lymphadenopathy 12.1%, vaginal bleeding 3.4%, and pelvic pain 5.4%.

STIs deserve attention not only because of their high prevalence but also because they frequently go undetected and untreated, and often result in serious sequelae and association with HIV infection.[3] High prevalence rates associated with high frequency of risk were observed in this ongoing study. These two factors identify female adolescents as an important group to reach with STI including HIV prevention efforts.

These data are descriptive and need to be completed but they are in agreement with the last research about Brazilian sexuality. It was reported that adolescents have their first intercourse earlier than the older generation and the knowledge about STI/AIDS does not modify the exposition.[4] Eighteen per cent of adolescents in Brazil become pregnant at least once and 54.1% among the married ones use some method of contraception.[5] The preliminary results suggest that humane, healthcare based, STI/HIV prevention services in the health family programme can be an acceptable intervention, as well as one that is highly targeted epidemiologically. Screening, treatment and prevention counselling, and support in communities should be considered

Table 1 Behavioural and clinical data among female adolescents

Variables	No	%
Tobacco use	45	30.2
Alcohol regular use	39	26.2
Cannabis use	22	14.8
Illicit drug abuse	56	37.6
Access to information about sexuality	104	69.8
Access to information about contraception	86	57.7
Regular medical consultation	92	61.7
Vaginal intercourse	97	65.1
Anal intercourse	8	5.4
Regular condom use*	31	31.9
Previous STI*	10	10.3
Pregnancy*	26	26.8
Rape*	13	13.4

*Data related to 97 adolescents that reported sexual intercourse.

and evaluated as a core component of STI/HIV prevention efforts in many or most places where STIs are public health problems.

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LETTERS

Factors affecting co-infection with genital chlamydia and genital gonorrhoea in an urban genitourinary medicine clinic

Co-treatment for chlamydia is common practice when gonorrhoea is diagnosed in a UK genitourinary medicine setting. In Glasgow, the incidence of gonorrhoea across the city has tripled from 1995 to 2000.[1] Given this rise, we investigated whether our practice of co-treatment was of continued benefit. We examined all patients presenting to the Glasgow Royal Infirmary Genitourinary Medicine (GUM) Service (including the Steve Retson Project service for gay men) between 1 April 1997 and 30 September 2000 who had genital gonorrhoea diagnosed on routine culture. We diagnosed genital chlamydia co-infection by ligase chain reaction (LCR) on first pass urine (for men) or endocervical swab (for women).

We diagnosed gonorrhoea in 351 attenders (287 men, 64 women), of whom 86 (25%; 95% CI 20% to 29%) were co-infected. Co-infection was significantly more common in women than men (29/64 (48%) *v* 57/287 (20%); p = 0.02). Homosexual or bisexual men were significantly less likely to be co-infected than heterosexual men (15/134 (11.0%) *v* 42/153 (28%); p = 0.001). Co-infection became less common with increasing age (15–19 years 43%; 20–24 years 34%; >24 years 18%; χ^2 for trend = 15.4; p <0.0001) (see table w1 on *STI* website). Logistic regression modelling showed young age and female sex to be independent predictors of co-infection, while homo/bisexuality was protective (see table w2 on *STI* website).

We recommend continuing co-treatment for chlamydia in all women and heterosexual men presenting with gonorrhoea in our setting. However, in common with other recent findings[2] co-infection with genital chlamydia is uncommon in male homosexual or bisexual attenders with genital gonorrhoea, and co-treatment may not be necessary in this group.

Two tables can be found on the *STI* website

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Screening for STIs in individuals with HIV infection

In Australia, Victoria has seen an increase in new HIV cases from 1999 to 2000,[1] and this rise has been sustained in 2001. The rise primarily involves men who have sex with men (MSM), where rates of unprotected anal intercourse and bacterial sexually transmitted infections (STIs) have also increased.[1] As bacterial STIs enhance HIV transmission,[2] screening for asymptomatic infections may reduce the incidence of HIV.

A sexual health service in Melbourne reviewed medical records of MSM clients with HIV infection. This was conducted to determine how commonly STI screening of asymptomatic clients is performed and the proportion with bacterial STIs. At the sexual health clinic the records of MSM with HIV care primarily at that clinic between 10 January 2001 and 1 March 2002 were reviewed. Any record of bacterial STI screening in the last year, the anatomical sites screened, and the laboratory results of screening were collected on printed forms. At the Alfred hospital a pilot programme screening asymptomatic clients with HIV (n = 40) was undertaken in the outpatient department between 30 October 2001 and 4 December 2001.

Of the 66 sexual health clinic records fulfilling the criteria, 22 (33%) had screening for bacterial STIs, and eight were tested at all anatomical sites of infection (urethra, rectum, throat). Of the 22 tested, three (14%) tested positive for *Neisseria gonorrhoeae* (NG) by culture and/or *Chlamydia trachomatis* (CT) by ligase chain reaction (LCR). Three had rectal infection (NG = 2, CT = 3), two also had pharyngeal infection (NG = 2), and one also had urethral infection (CT = 1). At the Alfred Hospital 40 clients had swabs taken from all sites. Of these 40, eight (20%) HIV infected clients had rectal NG detected by polymerase chain reaction (PCR) with confirmatory assay.

We identified a relatively high proportion of infections in those screened—11 positive of the 62 tested (18%, 95% CI 9% to 30%). These findings to do not mean that these individuals have been placing others at risk of HIV transmission because STIs may be acquired from unprotected sexual contact with other HIV infected individuals, or through sexual contact that is low risk for HIV transmission. Nevertheless, it would seem prudent to reduce the prevalence of STIs by making screening a routine part of the management of MSM. In the United States STI screening is recommended,[3] and screening of MSM is also recommended in the draft "STI management guidelines for priority populations" from the Australasian College of Sexual Health Physicians (Chris Bourne, personal communication).

Contributors

The data extraction was carried out by all authors and analysed by NL and CF. The article was drafted by all authors and all have approved the final draft. The authors declare that they have no conflict of interest in connection with this paper.

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